No. 97-218

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In The

Supreme Court of the United States

October Term, 1996

STEVEN B. LARSEN, IN HIS CAPACITY AS INSURANCE COMMISSIONER OF THE STATE OF MARYLAND,

Petitioner,

v.

AMERICAN MEDICAL SECURITY, INC., ET AL.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

BRIEF OF THE STATES OF MINNESOTA, ARIZONA, CALIFORNIA, COLORADO, DELAWARE, DISTRICT OF COLUMBIA, GEORGIA, HAWAII, IDAHO, KANSAS, MAINE, MASSACHUSETTS, MICHIGAN, MISSOURI, MONTANA, NEVADA, NEW HAMPSHIRE, NEW YORK, NORTH CAROLINA, NORTH DAKOTA, OREGON, TEXAS, VERMONT AS AMICI CURIAE IN SUPPORT OF PETITIONER

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BRIEF OF AMICI CURIAE IN SUPPORT OF PETITIONER

Pursuant to Supreme Court Rule 37, the signatory states respectfully submit this brief as amici curiae in support of Maryland's petition for a writ of certiorari.

STATEMENT OF INTEREST

The amici states have a strong interest in the resolution of the issue presented by this case because it has implications for two interrelated aspects of the states' police power functions: regulation of the insurance industry and maintenance of a stable and effective health care delivery system. If the decision of the Fourth Circuit is allowed to stand, and proliferate, each state's ability to perform those crucial functions for the protection of the health and welfare of the citizens will be significantly undermined.

As this Court has acknowledged, all states have long been involved in the active regulation of the insurance industry for the protection of their citizens. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 728 (1985). This regulation has ranged from assuring financial stability of companies offering insurance to mandating the substantive content of specific types of policies offered. *Id.* Specifically relevant to this case, the sale of health insurance has been subject to extensive regulation by the states. *Id.* Significantly, Congress has consistently and explicitly left regulation of the insurance industry to the states. *See*

McCarran-Ferguson Act, 15 U.S.C. § 1012 (1994)[1]; 29 U.S.C. § 1144(b)(2)(A) (1994) (ERISA insurance savings clause).

States also have played a long-standing role in the regulation of their health care systems. That role has been highlighted in recent years as states have enacted reforms intended to address the dual challenges of containing skyrocketing costs while providing adequate, quality care to all those in need.

By holding that Maryland's regulation of stop-loss insurance purchased by employer health benefit plans is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461, the Fourth Circuit's decision improperly infringes on both of these traditional police power functions of the states. Thus, the ruling below interferes with the proper balance between important state police powers and federal authority under ERISA.

The threat to the states' authority posed by the Fourth Circuit's decision is magnified by the scope of ERISA's reach. The United States General Accounting

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[1] Section 1012 provides:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance. . . .

15 U.S.C. § 1012 (1994).

Office recently estimated that 114 million individuals, or 44 percent of the U.S. population, were enrolled in ERISA health benefit plans in 1993. *See* U.S. General Accounting Office, *Employer Based Health Plans: Issues, Trends, and Challenges Posed by ERISA*, GAO/HEHS-95167, July, 1995, at 2. The broad impact that ERISA preemption decisions have on the ability of states to implement effective improvements in their health care systems is well-documented. *See* Jolee Ann Hancock, *Diseased Federalism: State Health Care Laws Fall Prey to ERISA Preemption*, 25 Cumb. L. Rev. 383 (1995); Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. Davis L. Rev. 255 (1990). Indeed, the proper scope of ERISA preemption in relation to the financing aspects of state health care systems has been before the Court in two recent Terms. *See New York State Conference of Blue Cross and Blue Shield Plans v. The Travelers Ins. Co.*, 115 S. Ct. 1671 (1995); *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 117 S. Ct. 1747 (1997).

The issue of the states' authority to regulate stop-loss insurance sold to self-funded ERISA health benefit plans, one of the leading challenges posed by ERISA, now has come to the fore. As reported by the General Accounting Office, almost forty percent of ERISA health benefit plans, covering 44 million people, are at least partially self-funded.[2] *See* U.S. General Accounting Office, *Employer Based Health Plans: Issues, Trends, and Challenges Posed by ERISA*, GAO/HEHS-95167, July, 1995, at 2-3. The

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[2] In this brief the terms "self-insurance" and "self-funded" are used interchangeably.

General Accounting Office found further that self-funding of ERISA plans was increasing, especially among smaller firms. *Id.* at 3.

Typically, ERISA plans provide health benefits to their employees either through the purchase of insurance or by self-insuring. As the General Accounting Office noted, however, the distinction between self-insured and fully insured plans "is growing more difficult as the health market changes. Among factors contributing to the confusion are more extensive use of stop-loss coverage and innovative arrangements between employers and managed care organizations." *Id.* at 8. The General Accounting Office also found that there is an "increasingly blurred distinction between self-funded and insured plans. . . . This results partly because employers are increasingly adopting funding arrangements that are neither fully insured nor fully self-funded." *Id.* at 3.

Stop-loss insurance typically has been viewed as business insurance to protect the insured from excessive claims based upon unexpected or catastrophic losses. Maryland recognized a trend whereby insurers issue stop-loss policies to self-funded health care plans that insure the risk at low attachment points. Such policies allow employers to shift more risk to the insurer. Insurance regulators in Maryland and other states have determined that by shifting more risk to the insurer, the stop-loss insurance functions more like direct health insurance and less as catastrophic stop-loss insurance. Consequently, the State of Maryland adopted regulations that impose the same requirements on stop-loss policies that function effectively as health care policies that are imposed on health care policies. In defining the point at

which "stop-loss" insurance would be treated as health insurance, the State of Maryland properly asserted its police powers over the insurance companies, requiring the insurance companies issuing those policies to comply with the consumer protection provisions required for health insurance. Such state action is necessary and appropriate to protect the consumers of the health insurance at issue. Further, it is an appropriate exercise of state police power as that authority has been reserved for the states under the McCarran-Ferguson Act.

The State of Maryland is not alone. Numerous states have adopted laws and issued interpretations to address this changing market and the blurring of lines between insured and self-insured plans.[3]

This Court has made it clear that ERISA plans that purchase group health insurance policies are subject to indirect regulation that results from the states' regulation of the insurance industry. *See Metropolitan Life*, 471 U.S. 724 (1985). The Court has not addressed the application of that principle to stop-loss insurance, and the federal courts of appeals that have addressed the issue are divided in their results. The Fourth Circuit's resolution of the issue not only failed to follow the decisions of this

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[3] *See* 1997 Alaska Sess. Laws, Ch. 81; Colo. Rev. Stat. § 10-16-119 (1995); CT Bulletin PC-7-90; Ks. Bulletin 1993-12 and 1997-7, Me. Rev. Stat. Ann., Tit. 24A § 707(1)(C-1) (1994) and June 5, 1992 Guideline; Minn. Stat. § 60A.235 (1995); Mo. Code Regs. Title 20, § 400-2.150 (1995); 27 N.J. Reg. 4320; Ok. Bulletin March 20, 1991; Or. Rev. Stat. § 742.065 (1995); Pa. Bulletin Vol. 22, No. 39 (1992); Tenn. Comm. and Ins. Bulletin October 18, 1995 and Tenn. Code Ann. § 56-2-201(1) (1994); and Wash. Rev. Code § 48.21.015 (1995).

Court, but severely limited the authority of the states to carry out their traditional duties to protect the health and welfare of their citizens. Until this Court speaks to the issue, states will be faced with an increasing number of insurance products that are labeled as "stop-loss" insurance to distinguish themselves from "health" insurance and thus avoid state regulation, when in fact they act as health insurance and should be regulated as such. The amici states therefore urge the Court to issue a writ of certiorari so it can address this increasingly important issue.

REASONS FOR GRANTING REVIEW

I. THE COURT OF APPEALS ERRONEOUSLY INTERPRETED THE ERISA PREEMPTION STANDARD IN A CASE THAT PRESENTS AN UNRESOLVED MATTER OF NATIONWIDE SIGNIFICANCE.

This case focuses on an unresolved ERISA preemption issue which triggers the complex interaction of: the general ERISA preemption clause, 29 U.S.C. § 1144(a) (1994); the insurance savings clause, 29 U.S.C. § 1144(b)(2)(A) (1994); and the deemer clause, 29 U.S.C. § 1144(b)(2)(B) (1994). In reconciling these opaque provisions, the Court has distinguished ERISA plans that provide benefits to their employees through the purchase of insurance from ERISA plans that self-insure, allowing states to regulate insurance companies, and thus indirectly regulate ERISA plans that purchase insurance, but prohibiting direct state regulation of self-insured ERISA plans. *Metropolitan Life v. Massachusetts*, 471 U.S. 724, 747 (1985). The instant case asks whether an employee benefit

plan can insulate itself from the indirect regulation recognized in *Metropolitan Life* merely by insuring something less than all of its risk.

The decision below effectively negates ERISA's insurance savings clause for an increasingly significant portion of the insurance market, thus thwarting Congress' express intent that the states retain their authority to regulate the business of insurance. The Maryland regulation at issue is not directed at ERISA plans. Rather, it is designed to prevent sham transactions whereby health insurance with a high deductible is labeled as stop-loss insurance by insurance companies to avoid state insurance regulation. The decision of the Court of Appeals invites subterfuge in the insurance industry. It also assumes that the insurance savings clause and deemer clause, when read together, prohibit the states from regulating a specific type of insurance. Nothing in the language of ERISA demands that result.

The Maryland regulation at issue is not an isolated or atypical state insurance law, and the problem it addresses is not unique to Maryland. The harm the Maryland regulation targets is precisely the type of harm which the states are best suited to address. It targets sharp business practices whereby form is placed above substance. As demonstrated in a recent enforcement action in Minnesota, consumer protection regulations similar to the Maryland regulation at issue protect the employers who purchase the insurance as well as their employees. Appendix at 17a. Moreover, the type of stop-loss insurance that precipitated the Maryland regulation is only one example of attempts by entities that provide health benefits to shift some of that risk to other parties. Shifting

of risk is a hallmark of the business of insurance and the states must be free to address these new and innovative ways of shifting risk if they are to carry out their duty to protect the public health and welfare.

II. THE DECISION BELOW CONFLICTS WITH THIS COURT'S DECISIONS IN *METROPOLITAN LIFE INS. CO. V. MASSACHUSETTS*, 471 U.S. 724 (1985), AND *FMC CORP. V. HOLLIDAY*, 498 U.S. 52 (1990).

The decision below directly conflicts with the prior decisions of this Court in *Metropolitan Life v. Massachusetts*, 471 U.S. 724, 747 (1985) and *FMC Corp. v. Holliday*, 498 U.S. 52 (1990). In *Metropolitan Life*, the Court held that a mandated-benefit law was state regulation of insurance within the meaning of the insurance savings clause and thus was saved from preemption under ERISA. A critical holding in that case recognized that the insurance contract between the plan and an insurer is saved from preemption, and that contract may be regulated by the states without invoking the deemer clause. Under the *Metropolitan Life* analysis, if a plan is completely self-insured the "deemer clause" prohibits the states from regulating the benefits provided by the plan. The Court recognized that such a distinction results in different rules applying to plans depending on whether the plan is self-insured:

> We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in

> the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter.

Id., 471 U.S. at 747. Accordingly, a plan that purchases insurance from a regulated insurer is subject to indirect regulation while self-insured plans are exempt from regulation under the deemer clause.

The Court reaffirmed *Metropolitan Life* in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), holding that the "deemer clause" exempts self-funded ERISA plans from state laws that "regulate insurance" within the meaning of the savings clause. *Id.* at 61. The Court explained:

> State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state regulation. An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

Id. at 61.

The Fourth Circuit erroneously failed to apply this Court's very clear directive. The regulation at issue is directed at stop-loss insurers, not ERISA plans. Those insurers should not be relieved from state regulation merely because they have sold their insurance to "self-

insured" employers. Similarly, the ERISA plans that purchase that insurance are indirectly subject to the state's regulation because they have chosen to purchase insurance to cover some of their risk, rather than remaining fully self-insured. The loophole created by the Fourth Circuit decision significantly erodes the states' ability to exercise their traditional regulation of insurance that Congress intended to protect with the insurance savings clause. By curtailing the states' ability to distinguish between true catastrophic or stop-loss insurance and traditional health insurance, the Court of Appeals invites the creation of a shadow insurance market that remains unregulated by either federal or state authority and is devoid of the protections that regulation would provide.

III. THE DECISIONS OF THE CIRCUIT COURTS OF APPEALS ARE DIVIDED ON THE ISSUE PRESENTED.

Review of the Court of Appeals' decision is necessary to resolve conflicting decisions issued by several courts of appeals. The Courts of Appeals for the Sixth Circuit and Seventh Circuit have opined that various state regulations are not preempted even though they act on stop-loss insurance purchased by ERISA plans. The Courts of Appeals for the Second Circuit and Ninth Circuit, however, determined that the purchase of stop-loss insurance does not convert ERISA plans to insured plans for purposes of the preemption analysis. This split in the courts has created uncertainty and confusion that can be resolved only by this Court. As noted by one commentator, "[e]ven those courts that ultimately agree on the issue

seldom employ the same analysis in arriving at their decisions; there is not only inconsistency between the circuits, there is even inconsistency within a circuit." Jeffrey Lenhardt, *ERISA Preemption: The Effect of Stop-Loss Insurance on Self-Insured Health Plans*, 14 Va. Tax. Rev. 615, 638 (1995).

In *Michigan United Food & Commercial v. Baerwaldt*, 767 F.2d 308 (6th Cir. 1985), *cert. denied*, 474 U.S. 1059 (1986), the Court of Appeals properly relied on the *Metropolitan Life* decision of this Court noting: "[T]he 'stop-loss' nature of the plans does not alter our conclusion. . . . As long as the plans purchase insurance from 'an insurer offering health insurance policies in Michigan, the policies must include the substance abuse coverage specified. . . . ' " *Id.* at 312-13.

Likewise, the Court of Appeals for the Seventh Circuit concluded an assessment imposed on sales by insurance companies may include sales of stop-loss insurance to self-funded ERISA plans. That court, following this Court's decision in *Travelers*, 115 S. Ct. 1671 (1995), held that the imposition of a fee on the insurer selling stop-loss insurance to an ERISA plan does not trigger federal preemption. *See Safeco Life Ins. Co. v. Musser*, 65 F.3d 647 (7th Cir. 1995).[4]

The Court of Appeals for the Ninth Circuit, however, ruled that the purchase of stop-loss insurance by ERISA

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[4] At least one state court has considered and rejected the analysis of the Fourth Circuit, choosing instead to rely on the Seventh Circuit's analysis. *American Trust Adm'rs, Inc. v. Sebelius*, No. 96-CV-908 (Kan. Dist. Ct. Shawnee Cty. April 25, 1997) Appendix at 1a, 7a.

plans did not convert those plans into insured plans. *See Moore v. Provident Life & Accident Ins. Co.*, 786 F.2d 922 (9th Cir. 1986), and *United Food and Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986). The Court of Appeals for the Second Circuit found ERISA preempted an Actuarial Letter issued by the State of New York that regulated stop-loss insurance contracts. *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708 (2d Cir. 1993), *rev'd on other grounds*, 115 S. Ct. 1671 (1995).

Interestingly, the Court of Appeals for the Fifth Circuit in *Brown v. Granatelli*, 897 F.2d 1351 (5th Cir. 1990), did not reach the question of whether the stop-loss insurance at issue there was preempted by ERISA because it concluded, "with one important qualification," that stop-loss insurance was not health and accident insurance. *Id.* at 1354. The "important qualification," however, is critical to the case at issue. That court noted:

> We do not suggest that Article 3.70-2(E) can be avoided by naming an employer benefit plan as the insured on a policy which in reality insures the plan participants. If, for example, a plan paid only the first $500.00 of a beneficiaries' health claim, leaving all else to the insurer, labeling its coverage stop-loss or catastrophic coverage would not mask the reality that it is close to the simple purchase of group accident and sickness coverage. We look beyond form to the substance of the relationship between the plan, the participants, and the insurance carrier to see whether the plan is in fact purchasing insurance for itself and not for the plan participants, recognizing that as insurance is less for

> catastrophic loss, it is increasingly like accident and sickness insurance for plan participants.

Id. at 1355.

Further, in a well-reasoned dissent, Judge Brown agreed with the Court of Appeals for the Sixth Circuit in *Michigan United Food* and stated that he would hold the stop-loss policy at issue in *Granatelli* was group accident and sickness insurance under Texas law. He recognized the issue presented was essentially a state law question and suggested that a better course would be to certify the matter to the Supreme Court of Texas, observing, however, that if the Court of Appeals for the Fifth Circuit reached the ERISA issue it should follow this Court's guidance in *Metropolitan Life*. *Granatelli*, 897 F.2d at 1356-59 (Brown, J., dissenting).

Clearly the federal appellate courts are split in their approach to handling this important issue, and thus it is imperative that this Court speak on the matter.

CONCLUSION

For the reasons stated above, the amici states respectfully urge this Court to issue a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit.

Dated: September, 1997

Respectfully submitted,

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September 20, 1995 Consent Order of the Minnesota Commissioner of Insurance *In the Matter of the Certificate of Authority of United Wisconsin Insurance Company and American Medical Security, Inc.* 17a

IN THE DISTRICT COURT OF
SHAWNEE COUNTY, KANSAS
DIVISION SIX

AMERICAN TRUST ADMINISTRATOR'S, INC., Petitioner,	)	Case No. 96-CV-908
v.	)	
KATHLEEN SEBELIUS, as Commissioner of Insurance for the State of Kansas, Respondent.	)	

MEMORANDUM DECISION AND ORDER

This case comes before the Court on American Trust Administrator's (ATA) Petition for Judicial Review. After careful consideration of the party's briefs, and for the reasons set forth below the Court hereby grants ATA's Petition for Judicial Review and overturns the decision of the Commissioner to disapprove the stop loss policy submitted by ATA.

FACTUAL BACKGROUND

The Commissioner of Insurance (Commissioner) issued Bulletin 1993-12 on May 25, 1993 and amended it on October 26, 1993. Bulletin 1993-12 reads, in relevant part:

1. The stop loss or excess loss policy shall be issued to and insure the plan or plan sponsor, not the individual participants.

2. Payment by the insurer shall be made to the plan sponsor or the plan itself, not the employees, members, participants, or providers.

3. The threshold for specific stop loss coverage shall be no less than $10,000 per individual participant.

4. The threshold for aggregate stop loss coverage shall be no less than 120% of expected claims.

5. The stop loss policy shall contain a provision that the plan's or the plan sponsor's bankruptcy or insolvency will not relieve the stop loss insurer from its obligation to pay claims under the stop loss policy.

6. The claim settlement period may be no less favorable than a 12/13 (incurred in 12/paid in 13).

As is obvious from reading the excerpt above, Bulletin 1993-12 regulates "stop loss" insurance. An employer who self-insures is health plan does not purchase group health insurance to insure its employees. Rather, the employer or the employer's plan pays the claims and the plan is indemnified by the employer. In other words a small employer who self-insures its health plan agrees to pay all plan benefits itself. Should a catastrophic health care problem strike one of the plan beneficiaries, that alone might be sufficient to bankrupt the employer. To protect against this risk, the employer, or the self-insured plan purchases stop loss insurance. The employer decides how much risk it can live with and purchase the appropriate amount of stop loss insurance, to cover the risk the employer does not believe it can accept. Bulletin 1993-12

sets limits on the amount of risk an employer can insure against in that it limits the amount of risks it allows stop loss carriers to cover.

Believing the Commissioner has exceeded her authority in promulgating Bulletin 1993-12, ATA sought approval of a policy which did not comply with the Bulletin. The Commissioner disapproved the proposed policy by letter dated July 6, 1995. After exhausting its administrative remedies, ATA seeks judicial review of the Commissioner's decision denying approval of the policy.

CONCLUSIONS OF LAW

In ruling on ATA's petition for judicial review, the Court must answer three questions: (1) does the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 et seq. preempt Bulletin 1993-12; (2) does the Commissioner have authority to regulate stop loss insurance; and, 3) if the Commissioner may regulate stop loss insurance, is Bulletin 1993-12 arbitrary and capricious?[1]

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[1] Respondent states that there is also a question as to whether respondent is entitled to summary judgment. The procedural posture of this case is muddled. Petitioner filed for judicial review and subsequently filed a Motion for Judgment on the Pleadings and Certified Agency Record. In its response, respondent argued that petitioner really filed a motion for summary judgment, responded accordingly and argued that in fact it was entitled to summary judgment. Rather than getting mired in the confused posture of this case, the Court treats the briefs as arguments why the respective parties believe the law is on their side, and will determine the issues on their merits.

In deciding these questions, the Court remains cognizant of the standard of review under The Act for Judicial Review. K.S.A. 77-621 provides that the party seeking the change of an order has the burden of showing that the agency has misapplied or misinterpreted the law or that a determination of fact is "not supported by evidence that is substantial when viewed in light of the record as a whole" or is otherwise arbitrary or capricious.

"Neither the district court nor an appellate court may substitute its judgment for that of the administrative agency." *Pork Motel, Corp. v. Kansas Dept. of Health & Environment,* 234 Kan. 374 (1983). So long as the record contains competent evidence in support of the decision of the Commission, its decision is reasonable and must be upheld by this court. *Kansas Transport Co., Inc. v. State Corporation Commission,* 202 Kan. 103 (1968).

1) Does ERISA (29 U.S.C. § 1001 et seq. Preempt the Commissioner's Bulletin 1993-12?

ERISA comprehensively occupies the field of law regarding employee pension and welfare plans. An employee welfare-benefit plan or welfare plan is defined as one which provides to employees 'medical, surgical, or hospital care or benefits, . . . whether these benefits are provided 'through the purchase of insurance or otherwise.' " *Metropolitan Life Insurance Co. v. Commonwealth of Massachusetts,* 471 U.S. 724, 732 (1985) (citing 29 U.S.C. § 1002(1)).

29 U.S.C. § 1144(a) provides: "Except as provided in subsection (b) of this section, the provisions of this subchapter . . . shall supersede *any and all State laws,* insofar

as they may now or hereafter relate to any employee benefit plan. . . . " (Emphasis added.) Given the breadth of the statute's language, Bulletin 1993-12 is preempted by ERISA unless "provided in subsection (b)" of the statute. Subsection (b), known as the "savings clause" provides: "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates *insurance*, banking or securities." (Emphasis added) Predictably, the parties do not agree as to whether Bulletin 1993-12 regulates insurance. The Commissioner claims that it does; ATA claims that it regulates self-funded benefit plans rather than insurance.

To determine whether a statute regulates insurance, the Court turns to *Metropolitan Life Insurance Co. v. Commonwealth of Massachusetts*, 471 U.S. 724 (1985). There, the *Metropolitan Life* Court found that a review of case law interpreting the McCarran-Ferguson Act, 15 U.S.C. § 1011 et. seq. to be helpful. "The case law concerning the meaning of the phrase 'business of insurance' in the McCarran-Ferguson Act, 15 U.S.C. § 1011 et seq., also strongly supports the conclusion that regulation regarding the substantive terms of insurance contracts falls squarely within the saving clause as laws 'which regulate insurance.' " *Id.* at 742-743. In determining whether Bulletin 1993-12 regulates "substantive terms of insurance contracts," the Court provided a three part test: (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and, (3) whether the practice is limited to entities within the insurance industry. *Id.* at 743.

It is clear that stop loss insurance has the effect of transferring or spreading a policyholder's risk. The whole reason to purchase stop loss insurance is to spread the risk from one entirely borne by the employer to one shared by the employer and a stop loss carrier. The Bulletin directly regulates how much risk can be transferred from the employer to the carrier. The second criteria is also met by the Bulletin in that it is directed at the policy relationship between the insurer and the insured. Its reason for existence is to determine the boundaries of that relationship. Finally, the Bulletin states that the Commissioner will disapprove any policies which do not meet this requirement. Consequently, the restrictions are limited to insurance companies. Under the McCarran-Fergusan test, it is clear that the Bulletin regulates the business of insurance.

Because Bulletin 1993-12 regulates insurance, it would seem to be saved from preemption by the "savings clause." This would end the inquiry except that there is an exception to the "savings clause" called the "deemer clause." This clause states "[n]either an employee benefit plan described . . . shall be deemed to be an insurance company . . . or engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies . . . " 29 U.S.C. § 1144(b)(2)(B). In other words, a statute that "relates to" an employee benefit plan is preempted unless it regulates insurance. However, even if the statute regulates insurance, it is preempted if it relates to a self-insured benefit plan. Because, petitioner argues that Bulletin 1993-12 is actually directed at self-insured benefit plans, an analysis of the scope of preemption under the "deemer clause" is necessary.

The Fourth Circuit, in *American Medical Security, Inc. v. Bartlett*, 1997 WL 169898 (April 11, 1997) recently decided precisely this question. In fact, this case is exactly on point with that decided by the *Bartlett* Court. There, the Maryland Insurance Commissioner promulgated guidelines which required stop loss carriers to provide minimum attachment points of $10,000 for any single beneficiary and an aggregate attachment point of 115% of expected total benefit payments paid under the plan.

Maryland argued that if the state did not set these attachment points, employers, through the use of self-funded ERISA plans, could bypass the State's minimum benefit requirements. This argument is mirrored by the Commissioner here. Just as in Maryland, the Commissioner mandates that all stop loss insurance which does not meet the requirements of the bulletin is deemed to be a health insurance policy for purposes of the State's insurance regulations.

The *Bartlett* Court upheld the Maryland District Court's decision that ERISA preempted the insurance regulation. The basis of this decision was that the regulation, while "carefully drafted to focus directly on insurance companies issuing stop-loss insurance," the regulation's "purpose and effect are directed at self-funded employee benefit plans." *Bartlett* at 5. As such, the regulation "related to" an employee benefit plan. Despite the fact that the *Bartlett* case is directly on point, is the only case that this Court could find that was, and is persuasive even though it is not binding, this Court rejects the holding of the *Bartlett* Court.

In Barlett, the strongest language supporting preemption is, "[w]here the existence of ERISA plans is essential to the [state] law's operation, . . . that 'reference' will result in preemption." *Bartlett* at 4 (citing *California Div of Lab. Stds. v. Dillingham Constr.* 117 S.Ct. 832 (1997)). A review of the cases citing this phrase indicate that in practice, Courts have interpreted its language much more restrictively than the language of the phrase would indicate.

In *California Div of Lab.,* the Court rejected preemption of a state law that regulated the pay received by participants in an employee benefit plan, despite the relationship of the law to an ERISA plan. They did so because the law need not effect a covered plan, it only did so in limited cases. It should be noted that the law in question in the *California Div. of Lab.* directly mandated benefits to be paid by ERISA plans, yet was not preempted.

Mackey v. Lanier Collections Agency, 100 L.Ed.2d 836 (1988) held that a Georgia law which prohibited the garnishment of a debtor's ERISA plan benefits was preempted. This law significantly touched upon ERISA plans in that it directed a plan sponsor not to pay out monies in the plan.

Other cases where preemption was found similarly were based upon laws that directly touched plan assets or benefit levels. *Shaw v. Delta Air Lines, Inc.,* 77 L.Ed.2d 490 (1983) (holding state law which prevented discrimination in employee benefit plans on the basis of pregnancy preempted by ERISA); *Pilot Life Insurance Company v. Dedeaux,* 481 U.S. 41 (1987) (holding claims based on

improper processing of claims for benefits under ERISA plan preempted); *FMC Corporation v. Holliday,* 112 L.Ed.2d 356 (1990) (holding laws that prevented an employee benefit plan from seeking subrogation for benefits paid preempted by ERISA); *Thompson v. Talquin Building Products Company,* 928 F.2d 749 (4th Cir. 1991) (holding state law which prevented health plans from denying coverage for injuries in automobile accidents preempted as far as that law related to self-funded plans).

The Bulletin at issue in this case does not require a self-funded plan to do anything. Self-funded plans are free to purchase stop loss insurance, or not purchase it. For those employers who decide to buy it (or for those who do not), the Bulletin does not require any particular level of benefit, does not mandate what must be covered or who must be covered. The Bulletin simply tells insurance companies what type of policy if may sell in Kansas. That it may affect employer's economic decisions about the type of health plan it provides does not, without more, bring the Bulletin within the preemption tentacles of ERISA.

This conclusion finds support in recent Supreme Court decisions. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.,* 115 S.Ct. 1671 (1995) involved state laws that set surcharges on insurance purchased by benefit plans where the insurance was not purchased from Blue Cross & Blue Shield ("the Blues"). The Court found that despite the fact that the surcharge made the Blues more attractive, "an indirect economic influence, however, does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself. . . . [N]or does the

indirect influence of the surcharges preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one. It simply bears on the costs of benefits and the relative costs of competing insurance to provide them. It is an influence that can affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges." *New York State Conference of Blue Cross & Blue Shield Plans* at 1679. These surcharges were not preempted despite the fact that their effects were felt predominantly by ERISA plans. *See also Cal. Div. of Lab. Stds. v. Dillingham,* 136 L.Ed.2d 791, 802 (1997).

Other Courts have also permitted laws that directly impacted stop loss insurance. In *Safeco Life Insurance Co. v. Musser,* 65 F.3d 647 (7th Cir. 1995), a Wisconsin statute that charged stop loss insurance carries a tax of $239,577.93 to pay for the State's Health Insurance Risk Sharing Plan was not deemed preempted by ERISA. The fact that this cost was going to be directly passed to ERISA self-insured plans did not persuade the Seventh Circuit that the law should be preempted. In coming to its decision, the *Safeco* Court looked to *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,* 116 S.Ct. 1671 (1995), relying particularly on the Supreme Court's statement that "[t]he basic thrust of the preemption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Safeco* at 651-52 (citing *Travelers* at 1678). There was nothing in Safeco, nor are

there any facts before this Court, indicating that regulation of stop loss insurance interferes with the "nationally uniform administration of employee benefit plans."

Although it did not have the benefit of the Supreme Court's wisdom in the *Traveler's* decision, *Safeco Life Insurance Co. v. Oregon Medical Insurance Pool,* 1992 WL 719700 (D.Or. 1992) comes to the same result. This case provides a similar factual situation to *Safeco Life Insurance Co. v. Musser,* 65 F.3d 647 (7th Cir. 1995) in that an Oregon statute taxed carriers providing stop loss insurance. The Oregon District Court held,

> Applying the deemer clause to the assessment statute in this case, I find that the Oregon statute treats self-funded plans as insureds, not insurers, and does not deem the self-funded plan as an insurer nor does it treat the plan like an insurance company. Like the tax in GM [General Motors v. California Bd. of Equalization, 815 F.2d 1305 (9th Cir. 1987], the assessment in this case is levied directly against the insurance company and as such, simply becomes part of the expense that SAFECO must pay in order to conduct business within this state.

Safeco Life Insurance Co. v. Oregon Medical Insurance Pool, 1992 WL 719700, 719701 (D.Or. 1992).

The case before this Court does not present economic effects nearly as strong as those found in *New York State Conference of Blue Cross & Blue Shield Plans.* Here, the Bulletin does not tax benefit plans either directly or indirectly. It simply provides that stop loss insurance carriers can only issue certain types of stop loss policies. Nothing in ERISA mandates that states allow employee welfare to

buy whatever they want, it only prevents states from interfering in the administration of employee benefit plans. Bulletin 1993-12 is not preempted because it does not impact the administration of an ERISA plan, but only controls what type of insurance may be purchased within Kansas.

2) **Does the Commissioner Have the Authority to Promulgate Bulletin 1993-12?**

ATA argues that there is no statutory authority within which the Commissioner may promulgate Bulletin 1993-12. The basis for this argument is that an administrative agency must regulate within the confines of its enabling statute and statutes relating to the area of law regulated by the agency. The Commissioner acknowledges that she is limited by Kansas law, but claims she has authority to regulate stop loss insurance as a result of K.S.A. 40-103, K.S.A. 40-216 and various provisions of Article 22 of Chapter 40 of the Kansas Statutes Annotated.

It is clear from the plain language of KSA 40-2201 et seq., that these statutes do no not authorize the Commissioner to regulate stop loss insurance. K.S.A. 40-2201 defines an accident and sickness policy as one that "includes any policy or contract insuring against loss resulting from sickness or bodily injury or death by accident or both . . . " A stop loss insurance contract insures the benefit plan for losses sustained by a benefit plan or an employer, not for injury or sickness. The Commissioner places great weight upon K.S.A. 40-2215(b) and K.S.A. 40-2210. Even a casual reading of these statutes

reveal they do support the Commissioner's contention that she may regulate stop loss insurance.

K.S.A. 40-2215 reads, in relevant part,

> No individual policy of accident and sickness insurance as defined in K.S.A. 40-2201 and amendments thereto shall be issued or delivered to any person in this state nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto, have been filed with the commissioner of insurance.

Again, a stop loss policy does not fall within the definition of an accident and sickness policy as defined by K.S.A. 40-2201.

K.S.A. 40-2210(A)(8) is similarly unhelpful to the Commissioner. This statute provides:

> (A)Blanket sickness and accident insurance is hereby declared to be that form of sickness and accident insurance covering special groups of persons as enumerated in one of the following paragraphs (1) to (8) inclusive.
>
> > (8) Under a policy or contract issued to any other type of group which the commissioner of insurance may find properly subject to the issuance of blanket sickness and accident policy or contract.

This argument by the Commissioner still does not get around the fact that stop loss insurance is not accident and sickness insurance as defined by K.S.A. 40-2201. Additionally, reading K.S.A. 40-2210(A)(1)-(7) indicates that these policies are sold to employers or businesses

that wish to insure against accidents that occur on their premises, or insures employees directly. Stop loss insurance does neither. Finally, a reading of K.S.A. 40-2210(B) shows clearly that the legislature did not intend to regulate stop loss insurance with this statute in that the provisions contained therein prescribe time frame within which a plan beneficiary must report their sickness or disability.

If the Commissioner has statutory authority to regulate stop loss insurance she must find it outside of K.S.A. 40-2201. In an attempt to do just that, the Commissioner points to K.S.A. 40-216 which provides in part:

> No contract of insurance or indemnity shall be issued or delivered in this state until the form of the same has been filed with the commissioner of insurance, nor if the commissioner of insurance gives written notice within thirty (30) days of such filing, to the company proposing to issue such contract, *showing wherein the form of such contract does not comply with the requirements of the laws of this state;* (Emphasis added)

ATA does not contest that the Commissioner has the power to disapprove insurance contracts which violate the laws of Kansas, they simply argue that stop loss insurance does not violate the law. K.S.A. 40-216 requires the Commissioner to show the insurer proposing a policy where the policy falls outside the laws of this State. This, so far, the Commissioner has been unable to do.

Finally, the Commissioner points to K.S.A. 40-103 to support her authority to regulate stop loss insurance. This statute is the catch all, providing the Commissioner with the power to generally makes rules "necessary to

enforce the laws of this state relating thereto." No one contests this power. However, because the Commissioner can point to no law violated by issuers of stop loss insurance whose policies fall below the criteria mandated by Bulletin 1993-12, K.S.A. 40-103 does not provide the Commissioner with power to promulgate the Bulletin.

This is supported by our Court of Appeals in *Durrett v. Bryan* 14 Kan.App.2d 723 (1990). There, an insurance company challenged an Insurance Department regulation which prohibited subrogation clauses in policies insuring persons against injuries suffered in automobile accidents. The *Durrett* Court stated:

> Administrative agencies are creatures of statute and their power is dependent upon authorizing statutes, therefore any exercise of authority claimed by the agency must come from within the statutes. There is no General or common law power that can be exercised by an administrative agency.
>
> Rules or regulations of an administrative agency, to be valid, must be within the statutory authority conferred upon the agency. Those rules or regulations that go beyond the authority authorized, which violate the statute, or are inconsistent with the statutory power of the agency have been found void. Administrative rules and regulations to be valid must be appropriate, reasonable and not inconsistent with the law.

Durrett at 727 (citing *Pork Motel, Corp. v. Kansas Dept. of Health & Environment,* 234 Kan. 374, 37-79 (1983). The *Durrett* Court then upheld the regulation only because it could find statutory authority for the regulation within K.S.A. 40-2203.

Here, there is no statutory support for the Commissioner's authority to regulate the attachment points of stop loss insurance policies. Consequently, the Court holds that the Commissioner does not have authority to issue Bulletin 1993-12. Because the Court so holds, it does not need to reach the issue of whether the limits within the Bulletin are arbitrary and capricious and declines to do so.

In conclusion, the Court finds that regulation of stop loss insurance is not preempted by ERISA because it is protected by the "savings clause" and does not fall within the "deemer clause." Insurance regulations that only remotely effect the economics of an ERISA plan are not preempted. Finally, the Court finds that the Commissioner is without authority to issue Bulletin 1993-12 because there is not statutory authority for her to regulate stop loss insurance attachment points.

JUDGMENT

For the reasons set forth above, the Court hereby grants ATA's Petition for Judicial Review and overturns the decision of the Commissioner to disapprove the stop loss policy submitted by ATA. The foregoing Memorandum Decision shall serve as the Court's entry of judgment, no further Journal Entry being required.

Dated this 25th day of April, 1997.

/s/ Terry Bullock
The Honorable
Terry L. Bullock
District Judge

STATE OF MINNESOTA
COMMISSIONER OF COMMERCE

In the Matter of the Certificate of Authority of United Wisconsin Insurance Company, a Wisconsin corporation, doing business in the State of Minnesota and the Third Party Administrator, Managing General Agent and Insurance Agency licenses of American Medical Security, Inc., a Delaware corporation doing business in the State of Minnesota.

CONSENT ORDER

TO: United Wisconsin Insurance Company, 401 West Michigan Street, Milwaukee, Wisconsin 53201 and American Medical Security, Inc., 3100 AMS Boulevard, Box 19032, Green Bay, Wisconsin 54307-9032 and their attorney, Gregory G. Scott, POPHAM, HAIK, SCHNOBRICH & KAUFMAN, LTD., Suite 3300, 222 South Ninth Street, Minneapolis, Minnesota 55402-3336.

Commissioner of Commerce James E. Ulland (hereinafter "Commissioner") has determined as follows:

1. The Commissioner has commenced formal action pursuant to Minn. Stat. §§ 45.027, subds. 6 and 7, 60A.052, 60H.07, 60H.08, subds. 1 and 2, 60K.11 and 72A.13 (1994) and § 60A.17, subds. 1(d) and 6(c) (1990) against the Certificate of Authority of United Wisconsin Insurance Company (hereinafter "Respondent UWIC"), a Wisconsin corporation, doing business in the State of Minnesota and the Third Party Administrator, Managing General Agent and Insurance Agency licenses of American Medical

Security, Inc. (hereinafter "Respondent AMS"), a Delaware corporation doing business in the State of Minnesota, based on the allegations contained in the Notice of and Order for Hearing and Order to Show Cause (hereinafter "Order to Show Cause") issued on behalf of the Commissioner by Deputy Commissioner Gary A. LaVasseur on May 15, 1995.

2. Respondents acknowledge that they have been advised of their right to a hearing in this matter, to present argument to the Commissioner, and to appeal from any adverse determination after a hearing, and Respondents hereby expressly waive those rights. Respondents further acknowledge that they have been represented by legal counsel throughout these proceedings. Respondents expressly reserve the right, in the future, to challenge the authority of the State of Minnesota and the State of Minnesota Department of Commerce to regulate the terms and conditions of self-funded welfare benefit plans and stop loss policies including Counts V, VIII, IX, X, XI and XII contained in the Order to Show Cause. This express reservation does not effect Respondents' obligation to comply with the terms of this Consent Order including the civil penalty provision and the provisions of paragraphs "A" through "F."

3. Respondents, without admitting the allegations referenced herein, have agreed to informal disposition of this matter without a hearing as provided under Minn. Stat. § 14.59 (1994) and Minn. R. 1400.5900 (1993).

4. The following Order is in the public interest.

NOW, THEREFORE, IT IS HEREBY ORDERED, pursuant to Minn. Stat. §§ 45.027, subds. 6 and 7, 60A.052,

60H.07, 60H.08, subds. 1 and 2, 60K.11 and 72A.13 (1994) and § 60A.17, subds. 1(d) and 6(c) (1990), and other applicable law, that Respondents shall pay to the State of Minnesota Department of Commerce a civil penalty of $62,500 to be remitted by Respondents upon execution of the attached Consent to Entry of Order;

IT IS FURTHER ORDERED that:

A. Respondents will send the letter attached hereto as Exhibit A (hereinafter "the letter"), to all of the Minnesota employers (hereinafter "employers") who currently have "self-funded" health insurance plans and United Wisconsin Insurance Company stop loss policies with individual attachment points below $10,000.

B. Respondents will use the following procedure with respect to mailing the letter:

1. The letter will be sent to each employer by certified mail within three weeks of the date this Consent Order is executed; and

2. Ninety days after mailing the letter, Respondents will send the Minnesota Department of Commerce (hereinafter "Department"): (a) copies of the signed, certified mail, return receipt cards; (b) a list of the employers to whom the letter was sent; and (c) an affidavit signed by a corporate officer of each Respondent stating that the letter was mailed to all of the employers referenced in paragraph "A" above.

C. After the employers receive the letter, Respondents will use the following procedure regarding contact with employers:

1. Respondents will not initiate contact with the employers for 30 days regarding the content of the letter. Respondents will also instruct their agents, in writing, not to initiate contact with the employers for 30 days regarding the content of the letter. It is acknowledged that the employers, however, are free to contact Respondents or their agents at any time following receipt of the letter;

2. Respondents will keep a log of all communications (hereinafter "Respondents' log") with employers who call Respondents within 30 days and allege that at the time of sale, they did not understand the distinction between incurred and paid claims and/or the significance of that distinction (hereinafter the "incurred/paid issue"). Respondents will also instruct their agents, in writing, to keep a log of all communications (hereinafter "agents' log") with employers who call the agents within 30 days and allege that at the time of sale, they did not understand the distinction between incurred and paid claims and/or the significance of that distinction.

3. Respondents and their agents will not contact an employer regarding the "incurred/paid issue" after receiving notice from the Department that the employer has made an allegation to the Department regarding this issue unless the Department refers the employer to Respondents or their agents.

D. If an employer makes an allegation to the Department regarding the "incurred/paid issue" within 30 days of receiving the letter, the Department and Respondents will adhere to the following procedure:

1. The Department will send Respondents a copy of any written allegation made by an employer or if there is no written allegation, a letter describing the verbal allegation;

2. Respondents will have 15 days to respond to the Department in writing;

3. The Department will consider both the allegation of the complainant and Respondents' response, and make a decision as to whether the employer's health plan, including the stop loss policy, may be required to pay claims on an incurred rather than a paid basis. In making this decision, the Department will use its experience and expertise to weigh the evidence to determine whether, at the time of sale, the complainant was mislead regarding the distinction between incurred and paid claims, and/or the significance of that distinction, due to the actions or omissions of Respondents or their agent including failure to explain the incurred/paid distinction at the time of sale. The Department will weigh: the allegations of Respondents and the complainant; the information provided by the agent who sold the Flex Funding Plan and stop loss policy to the complainant; any other written evidence; the knowledge and sophistication of the complainant pertaining to insurance and employee benefit plans; and the credibility of any witnesses contacted by the Department.

4. Based on the procedure described in paragraphs "D1," "D2" and "D3" above, the Department will decide whether to require Respondents to pay claims on an incurred basis. Respondents will abide by that decision and pay incurred claims in accordance with the

requirements of the claims settlement laws of Minnesota, Minn. Stat. ch. 72A (1994).

5. If Respondents do not respond within 15 days as provided for in paragraph "D2" above, the employer's health plan, including the stop loss policy, will pay claims on an incurred basis in accordance with the requirements of the claims settlement laws of Minnesota, Minn. Stat. ch. 72A (1994).

6. Employers who have already alleged to the Department that they did not understand the incurred/paid distinction will have their allegations handled as described in "D3" and "D4" above.

E. Within 90 days of mailing the letter, Respondents will provide the Department with a complete list of employers who chose to convert to a fully insured plan and with a copy of the Respondents' and agents' logs described in paragraph "C2" above.

F. One year after mailing the letter, Respondents will provide the Department with an accounting of claims paid on an incurred rather than a paid basis due to this Consent Order.

This Order shall be effective upon signature on behalf of the Commissioner.

Dated: 9-20-95

JAMES E. ULLAND
Commissioner of Commerce
State of Minnesota

/s/ Gary A. LaVasseur
GARY A. LaVASSEUR
Deputy Commissioner
Enforcement and Licensing
Divisions

133 East Seventh Street
Saint Paul, Minnesota 55101
Telephone: (612) 296-2594

CONSENT TO ENTRY OF ORDER

The undersigned, American Medical Security, Inc., and United Wisconsin Insurance Company, state that they have read the foregoing Consent Order; that they know and fully understand its contents and effect; that they have been advised of their right to a hearing; that they have been represented by legal counsel in this matter; and that they consent to entry of this Order by the Commissioner of Commerce. It is further expressly understood that this Order constitutes the entire settlement agreement between the parties hereto, there being no other promises or agreements, either expressed or implied.

/s/ (illegible) V.P. (illegible) Gen Couns
American Medical Security, Inc.
[SEAL]

STATE OF WISCONSIN)
) ss:
COUNTY OF Brown)

Acknowledged before me this
18day of September, 1995.

/s/ Rita A. Hurley
Notary Public

/s/ Mary Traves
United Wisconsin
Insurance Company

STATE OF WISCONSIN)
) ss:
COUNTY OF MILWAUKEE)
[SEAL]

Acknowledged before me this
9th day of September, 1995.

/s/ Lana Hertel
Notary Public

EXHIBIT A

[AMERICAN MEDICAL SECURITY LETTERHEAD]

[DATE]

Dear FlexFunding Plan Sponsor:

As a result of changes in Minnesota law and in cooperation with the Minnesota Department of Commerce, American Medical Security and United Wisconsin Insurance Company are offering you a new health-care benefits package. For the next 30 days (until October ___, 1995), you may immediately convert your FlexFunding Plan with American Medical Security and United Wisconsin Insurance Company into a conventional, fully insured group health insurance policy.

If you do not choose this option, you may continue with your current FlexFunding Plan. If you choose to keep your current plan, on your renewal date, the stop loss attachment point of your plan will increase to $10,000 as required by new Minnesota law. In addition, new Minnesota law requires that if you have 49 or fewer employees, your current FlexFunding Plan will be changed so that claims are paid on an "incurred" rather than a "paid" basis.

DIFFERENCE BETWEEN COVERAGE ON AN "INCURRED" AND "PAID" BASIS

The Fully Insured Option

The fully insured group health insurance option would operate on an "incurred" basis, rather than on a "paid" basis as your current FlexFunding Plan operates.

The difference between a "paid" basis and an "incurred" basis can be explained with the following hypotheticals:

"INCURRED" Basic Coverage

Say, for example, that your conventional, fully insured group health insurance policy is in effect for a one-year term, from January 1, 1995 through December 31, 1995. An expense is incurred on October 30, 1995, but it is not submitted to American Medical Security until December 7, 1995. American Medical Security finishes processing the claim for payment and reimbursement by January 7, 1995 [sic]. Even though the expense is not processed until after December 31, 1995, the date the insurance policy terminates, the expense nevertheless will be covered by the policy.[1] This is because the expense was "incurred" during the policy year.

FlexFunding-Coverage on a "PAID" Basis

Under your current FlexFunding Plan, however, coverage is different. Again, suppose that your FlexFunding Plan is in effect for one year, from January 1, 1995 through December 31, 1995. An expense is incurred on October 30, 1995, is submitted to American Medical Security for processing on December 7, 1995, but is not processed for payment and reimbursement until January 7, 1995 [sic]. This expense will not be covered under the FlexFunding Plan because although it was incurred during the plan year,

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[1] This assumes that the expense would otherwise be covered under the terms of the policy.

the expense was not processed and "paid" by American Medical Security by the end of the year.[2]

THE OPTIONS AT RENEWAL

If you choose not to accept this offer to immediately convert to a fully insured group health insurance policy with American Medical Security and United Wisconsin Insurance Company, this option will again be available when it is time to renew your FlexFunding Plan.

At renewal time, you also may choose to retain the benefits of FlexFunding by designing a new FlexFunding Plan. Based upon recently enacted legislation in the State of Minnesota, this new Plan must have the following minimum features:

* a specific attachment point (i.e., your maximum claims cost per covered individual) of $10,000 or more; and

* an aggregate attachment point (i.e., the maximum amount of medical claims you could pay for your entire group in a plan year) that is lower than the sum of (i) 140% of the first $50,000 of expected plan claims, (ii) 120% of the next $450,000 of expected plan claims; and (iii) 110% of the remaining expected plan claims.

In addition, if you have 49 or fewer employees, claims will be covered on an "incurred" not a "paid" basis.

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[2] This expense would be covered under the terms of a separate policy, however, if you purchased terminal liability insurance.

Finally, of course, you always have the option to terminate coverage with American Medical Security and United Wisconsin Insurance Company. If you terminate coverage claims that are "incurred" but not processed and "paid" as of the termination will not be covered.

If you have any questions regarding this option to immediately convert to a fully insured group health insurance policy, or if you have questions about your options at renewal, you may contact American Medical Security or the Minnesota Department of Commerce, 113 East Seventh Street, St. Paul, Minnesota 55101 (Telephone: 612/296-2488), within 30 days of receipt of this letter.

Once again, the deadline to immediately convert your FlexFunding Plan into a conventional, fully insured group health insurance policy is October ___, 1995. For more information regarding rates and terms, contact American Medical Security at 1-800-232-5432.

As always, American Medical Security and United Wisconsin Insurance Company appreciate your business.

Very truly yours,

_____

_____

_____